PERSPECTIVES ON FUTURE HEALTH CARE

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(GREFTINGS TO HOSTS, GUESTS, ETC.)

I'M DELIGHTED TO BE YOUR GUEST THIS MORNING. THESE ANNUAL A.P.A. CONVENTIONS ARE AWESOME EVENTS. CONSIDERING THE COMPETITION ALL ABOUT TOWN, YOUR ATTENDANCE FOR THIS SESSION IS VERY MUCH APPRECIATED. I HONESTLY WOULDN'T BEGIN TO GUESS HOW YOU CHOOSE THE SESSIONS YOU'RE HOPING TO ATTEND. THAT IN ITSELF MIGHT BE A FIT SUBJECT FOR RESEARCH, IF IT'S NOT ALREADY INCLUDED IN A "POSTER SESSION" THIS VERY WEEK.

SO, TO BE HONEST WITH YOU, I'M HAPPY TO BE STANDING UP <u>HERE</u>, RATHER THAN SITTING DOWN <u>THERE</u>. I HAVEN'T HAD TO SUFFER THE AGONIES OF CHOICE.

BUT THIS MAY BE ONE OF THE FEW TIMES THAT CHOICE IS REALLY OUT OF MY HANDS. THE FACT IS THAT THE PUBLIC HEALTH FIELD TODAY IS CONFRONTED BY A RANGE OF CHOICES THAT HAVE TO BE MADE. THE PEOPLE MAKING THOSE CHOICES ARE IN PROFESSIONAL SOCIETIES, SUCH AS THE A.P.A., THEY ARE IN OUR COLLEGES AND UNIVERSITIES AND OUR VOLUNTARY ASSOCIATIONS, THEY'RE IN PRIVATE BUSINESS, AND THEY'RE IN LOCAL, STATE, AND FEDERAL GOVERNMENT.

THE PRESENCE OF A RANGE OF DIFFICULT CHOICES SHOULD TELL US THAT HEALTH CARE HOLDS A VITAL, CENTRAL POSITION IN THE PUBLIC MIND. AND THE INVOLVEMENT OF SO MANY DIVERSE AND KNOWLEDGEABLE INTERESTS SHOULD GUARANTEE THAT WE HAVE SERIOUS DEBATE ON EACH CHOICE WE MAKE. GRANTED, THIS IS NOT A PARTICULARLY NEAT PROCESS OF SOCIAL GROWTH -- BUT IT'S ALL OURS. THEORIES AND PRACTICES COME AND GO, YET WE ARE CONDUCTING THE PUBLIC BUSINESS NOW PRETTY MUCH AS AMERICANS DID NEARLY TWO CENTURIES AGO, WHEN DETOQUEVILLE OBSERVED THEM AND RECORDED HIS IMPRESSIONS. OUR SOCIETY REMAINS OPEN, OUR AGENDA IS FULL TO OVER-FLOWING, AND FULL PARTICIPATION BY EVERYONE IS OUR NATIONAL GOAL.

BUT AS WE LEAVE THAT LOFTY PLATEAU OF SOCIAL THEORY AND COME CLOSER TO THE PARTICULAR HEALTH CARE ISSUES OF OUR OWN DAY -- THE ONES THAT REQUIRE US TO CHOOSE AND CHOOSE NOW -- THE DEBATE BECOMES VERY COMPLEX. IT'S AT THIS POINT THAT I AM REMINDED OF THE OPINION OF A MORE RECENT FRENCH WRITER THAT "MORALITY MAY CONSIST SOLELY IN THE COURAGE OF MAKING A CHOICE."

SO THIS MORNING, I WANT TO SHARE WITH YOU A FEW OF MY THOUGHTS ON THOSE PUBLIC HEALTH ISSUES THAT ARE BEGINNING TO TEST OUR COURAGE. IN THE COURSE OF MY REMARKS, I HOPE YOU DON'T MIND IF I OCCASIONALLY SUGGEST WHAT THE PSYCHOLOGIST'S SPECIAL CONTRIBUTION MIGHT BE.

A NUMBER OF IMPORTANT ISSUES FIT TOGETHER UNDER THE GENERAL HEADING OF "DISEASE PREVENTION AND HEALTH PROMOTION." THIS IS AN AREA THAT'S ALREADY RECEIVING A GREAT DEAL OF ATTENTION FROM BOTH THE BEHAVIORAL AND THE BIOMEDICAL SCIENCES. I THINK THAT THE MOST COMPREHENSIVE GUIDANCE YOU CAN GET FOR EXPLORING THIS AREA LIES IN THE PAGES OF A BENCHMARK PUBLICATION CALLED HEALTHY PEOPLE, PUT OUT BY THE PUBLIC HEALTH SERVICE NOT TOO LONG AGO. IT IS SUBTITLED "THE SURGEON GENERAL'S REPORT ON HEALTH PROMOTION AND DISEASE PREVENTION."

HEALTHY PEOPLE REPRESENTS A CONSENSUS IN PREVENTION AND HEALTH PROMOTION. IT IS BASED UPON CONTRIBUTIONS FROM SOME 2,000 NON-GOVERNMENT EXPERTS REPRESENTING A BROAD SPECTRUM OF HEALTH AND SOCIAL SERVICE DISCIPLINES. A NUMBER OF PSYCHOLOGISTS, SEVERAL FROM DIVISION 38 ITSELF, CONTRIBUTED TO THIS REPORT, FOR WHICH WE ARE ALL IN YOUR DEBT. THE REPORT SHOWS HOW EACH OF OUR MAJOR PUBLIC HEALTH ISSUES AFFECTS AMERICANS OF DIFFERENT DEMOGRAPHIC, OCCUPATIONAL, AND SOCIOECONOMIC BACKGROUNDS. IT ALSO INDICATES HOW WE MIGHT HELP RESOLVE SOME OF THOSE ISSUES DURING THE DECADE OF THE 1980s.

I STRONGLY RECOMMEND THAT YOU READ <u>HEALTHY PEOPLE</u> AND THE IMPORTANT FOLLOW-UP DOCUMENT CALLED <u>PROMOTING HEALTH AND PREVENTING DISEASE:</u>

OBJECTIVES FOR THE NATION. THIS SECOND PUBLICATION IS A BIT DIFFERENT, IN THAT IT SETS OUT SPECIFIC, MEASURABLE GOALS FOR THIS DECADE AND THE STEPS WE MIGHT TAKE TO ACHIEVE THEM. THIS MATERIAL INCLUDES THE STEPS WE OUGHT TO TAKE IN ORDER TO BRING ABOUT...

- * FULL IMMUNIZATION FOR AT LEAST 95 PERCENT OF ALL SCHOOL-AGE CHILDREN BY THE YEAR 1990...
- * A DECLINE IN THE INFANT MORTALITY RATE FROM THE PRESENT 11.5
 DEATHS PER 1,000 LIVE BIRTHS DOWN TO 9 DEATHS PER 1,000...
- * LONG-TERM BLOOD PRESSURE CONTROL FOR AT LEAST 60 PERCENT OF THE POPULATION WITH DEFINITE HYPERTENSION, THAT IS, WITH A READING OF 160 OVER 95...
- * A DROP IN ADULT CIGARETTE SMOKING DOWN TO BELOW 1 PERSON IN 4: IT IS NOW 1 IN 3.

THESE ARE NOT ALL THEM. THERE ARE MULTIPLE OBJECTIVES IN 15 DIFFERENT HEALTH AREAS. BUT I HOPE YOU ARE STIMULATED BY MY FEW REMARKS TO READ BOTH REPORTS, SINCE THEY PROVIDE ALL OF US WITH A KIND OF ROADMAP OF WHERE WE'RE HEADED AND HOW WE HOPE TO GET THERE.

ONE CLEAR THREAD THAT RUNS THROUGH THESE REPORTS IS THIS: THAT OUR SOCIETY WILL ACHIEVE ITS HEALTH GOALS PRIMARILY THROUGH CHANGES IN BEHAVIOR NOT ONLY AMONG THE PUBLIC IN GENERAL BUT ALSO AMONG HEALTH PROFESSIONALS THEMSELVES. THE CLEAREST EXAMPLE OF THIS IS CIGARETTE SMOKING, THIS COUNTRY'S NUMBER ONE PREVENTABLE CAUSE OF DEATH.

EVER SINCE THE FIRST SURGEON GENERAL'S REPORT ON SMOKING AND HEALTH BACK IN 1964 THERE HAS BEEN A 42 PERCENT DROP IN THE NUMBER OF SMOKERS. BUT ABOUT 53 MILLION AMERICANS <u>STILL</u> SMOKE. SOME GROUPS -- ADOLESCENTS AND YOUNG ADULT WOMEN, FOR EXAMPLE -- HAVE HAD INCREASES IN SMOKING UNTIL VERY RECENTLY. AS A RESULT, SMOKING REMAINS OUR TOP HEALTH HAZARD. IT WILL CAUSE AN ESTIMATED 340,000 PREMATURE DEATHS IN THIS CALENDAR YEAR ALONE.

AS WE INDICATED IN OUR ANNUAL REPORT OF LAST FEBRUARY, ABOUT A THIRD OF THESE DEATHS ARE FROM SMOKING-RELATED CANCER. IN THE REPORT NOW IN PREPARATION, TO BE RELEASED EARLY IN 1983, WE WILL LAY OUT THE DATA TO ILLUSTRATE THE CAUSAL RELATIONSHIP BETWEEN SMOKING AND CARDIOVASCULAR DISEASE. IT IS EQUALLY AS CONVINCING.

THERE IS, HOWEVER, NO VACCINE AGAINST THE SMOKING HABIT. THERE IS NO DISCREET SURGICAL PROCEDURE, NO DRUG, NO FOOD, OR NO MAGIC THERAPY THAT IS SAFE AND EFFECTIVE FOR SMOKING CESSATION. QUITTING THE HABIT IS ENTIRELY A PERSONAL DECISION BY THE SMOKER. BUT GETTING A SMOKER TO MAKE THAT DECISION -- AND TO STICK WITH IT -- IS A COMPLEX BEHAVIORAL PROBLEM.

SMOKERS WHO DECIDE TO BREAK THE HABIT PREFER TO DO IT ON THEIR OWN. A NATIONAL CANCER INSTITUTE REPORT INDICATED THAT AS MANY AS 95 PERCENT OF THOSE WHO QUIT SMOKING DID SO WITHOUT THE HELP OF ANY ORGANIZED SMOKING CESSATION PROGRAM. THEY LEARNED THINGS FROM BOOKS OR MAGAZINE ARTICLES AND WERE ENCOURAGED BY RADIO AND TV PUBLIC

SERVICE ANNOUNCEMENTS. VERY FEW -- ABOUT 5 PERCENT -- SOUGHT THE HELP OF CLINICS, SEMINARS, OR GROUP SESSIONS.

OUR UNDERSTANDING IS STILL VERY CRUDE, CONCERNING WHICH MESSAGES EFFECTIVELY TURN SMOKERS AROUND. IN ADDITION, WE HAVE A MIXED PICTURE ON THE ABILITY OF EX-SMOKERS TO STAY AWAY FROM CIGARETTES. WE STILL DON'T KNOW WHICH REWARD SYSTEMS ARE THE MOST RELIABLE. AND WE'RE STILL EXPERIMENTING WITH MAKING CHANGES IN CERTAIN CLOSED ENVIRONMENTS -- NON-SMOKING SECTIONS IN RESTAURANTS, FOR EXAMPLE, OR SMOKING BANS ON PUBLIC TRANSPORTATION. AND SHOULD WE EMPHASIZE SELF-MANAGEMENT OR SHOULD WE ENCOURAGE THE INVOLVEMENT OF FRIENDS, FAMILIES, CO-WORKERS AND EMPLOYERS, AND "CONCERNED OTHERS?"

THAT KIND OF INFORMATION CAN LITERALLY SAVE LIVES. THE UNITED STATES CANNOT AFFORD THE HUNDREDS OF THOUSANDS OF PREMATURE SMOKING-RELATED DEATHS EVERY YEAR NOR CAN IT AFFORD THE ESTIMATED \$13 BILLION IN HEALTH COSTS AND \$25 BILLION IN LOST PRODUCTION AND WAGES THAT CAN BE TRACED TO THE EFFECTS OF CIGARETTE SMOKING.

BEHAVIORAL CHANGE AMONG THE SMOKING PUBLIC IS A MAJOR NATIONAL PUBLIC HEALTH PRIORITY. BUT THOSE OF US IN THE HEALTH PROFESSIONS HAVE A SIMILAR PRIORITY. IN HIS "FOREWORD" TO THIS YEAR'S SMOKING REPORT, DR. EDWARD N. BRANDT, JR., THE ASSISTANT SECRETARY FOR HEALTH, DIRECTED A FEW REMARKS AT OUR COLLEAGUES IN MEDICINE:

"AS A PHYSICIAN," DR. BRANDT WROTE, "I ENCOURAGE ALL HEALTH CARE PROVIDERS, PARTICULARLY OTHER PHYSICIANS, TO COUNSEL CIGARETTE SMOKERS TO QUIT AND TO GIVE THEM AS MUCH SUPPORT AS POSSIBLE...A FEW MINUTES' DISCUSSION WITH PATIENTS ABOUT THEIR SMOKING BEHAVIOR CAN HAVE A DECISIVE IMPACT ON WHETHER THEY QUIT SMOKING OR CONTINUE THE HABIT."

THIS IS MORE THAN JUST A ROUTINE REQUEST. AS MOST OBSERVERS OF THE MEDICAL PROFESSION KNOW, THE EDUCATION OF PHYSICIANS, DENTISTS, NURSES, AND OTHER PRIMARY HEALTH CARE PROFESSIONALS IS <u>STRONG ON CURING AND REPAIRING</u> AND <u>WEAK ON PREVENTING</u>. THERE'S A LOT OF LEARNING, <u>RE</u>-LEARNING, AND <u>UN</u>-LEARNING TO BE DONE BY PHYSICIANS ESPECIALLY, IF WE HOPE TO SIGNIFICANTLY REDUCE THAT CURRENT GROUP OF 53 MILLION SMOKERS.

THERE ARE SOME SUBTLETIES TO EXPLORE, ALSO. FOR EXAMPLE, IF WE CAN CONVINCE FAMILY PHYSICIANS TO RELAY A STRONG ANTI-SMOKING MESSAGE TO THEIR PATIENTS, WILL THEY DO THIS WITH THEIR OLDER PATIENTS AS WELL? WE HAVE STRONG SUSPICIONS -- AND SOME ANECDOTAL DATA -- THAT INDICATE PHYSICIANS MAY SUFFER FROM "AGE PREJUDICE" AS MUCH AS THE REST OF THE COUNTRY DOES. WOULD A PHYSICIAN TRY TO CONVINCE A 65-YEAR-OLD SMOKER TO QUIT -- OR WOULD THE PHYSICIAN THINK "IT'S TOO LATE TO DO ANY GOOD."

IT'S MY FEELING THAT THERE MAY BE TOO MANY PHYSICIANS WHO CAN'T BRING THEMSELVES TO PRACTICE GOOD PREVENTIVE MEDICINE WITH PEOPLE WHO ARE 60 OR 65 YEARS OLD. EVEN THOUGH, DEPENDING ON THEIR SEX AND THEIR GENERAL HEALTH STATUS, THOSE SENIOR CITIZENS STATISTICALLY MAY HAVE AS MANY AS 15 TO 18 YEARS OF LIFE AHEAD OF THEM.

HOW SHOULD WE GO ABOUT TO CHANGE THE SMOKING BEHAVIOR OF PHYSI-CIANS, DENTISTS, NURSES, AND OTHER PERSONS WHO PROVIDE HEALTH CARE? THIS KIND OF THING COMES UP IN OTHER AREAS AS WELL: GETTING PHYSICIANS TO ADVOCATE WEIGHT CONTROL, THE USE OF SEAT-BELTS, AND THE CONTROL OF DRINKING AND DRUG USE. NOW WE'RE ASKING THEM TO ENCOURAGE PATIENTS TO STOP SMOKING -- EVEN THOSE PATIENTS THEY CONSIDER TO BE "OVER THE HILL."

I THINK IT IS CLEAR THAT THE ANTI-SMOKING CHALLENGE -- ONE OF THE MOST SERIOUS CHALLENGES WE NOW FACE -- CAN BE MET ONLY IF THERE IS A PROFOUND AND PERMANENT CHANGE IN BEHAVIOR AMONG BOTH THE GENERAL PUBLIC -- REGARDLESS OF THEIR SEX OR AGE OR SOCIAL CONDITION -- AND ALSO AMONG THE PROFESSIONALS WHO PROVIDE THEM WITH THEIR HEALTH CARE, PREVENTIVE AS WELL AS CURATIVE.

THIS DOUBLE CHALLENGE RUNS THROUGH MOST OF OUR PRIORITY PROGRAMS IN HEALTH PROMOTION AND DISEASE PREVENTION. IN THE ONES I JUST MENTIONED, THE BEHAVIORAL FACTOR -- OR "LIFESTYLE" -- IS THE SINGLE MOST IMPORTANT FACTOR. BUT IN OTHER AREAS, THERE IS A COMPLEX RELATIONSHIP BETWEEN BEHAVIORAL AND BIOMEDICAL MEDICINE IN PREVENTING DISEASE AND PROMOTING HEALTH. HYPERTENSION OFFERS A GOOD EXAMPLE OF THIS.

HAVING ONCE IDENTIFIED A PATIENT AS HYPERTENSIVE, A PHYSICIAN WILL TEND TO MOVE IMMEDIATELY INTO DIET CONTROL AND DRUG THERAPY TO BRING DOWN THE DIASTOLIC PRESSURE. EQUALLY IMPRESSED WITH THE NEED FOR

URGENCY, THE PATIENT WILL TEND TO FOLLOW BOTH THE DRUG AND THE BEHAVIORAL REGIMENS. EARLY SUCCESS WITH HYPERTENSION CONTROL IS USUALLY HIGH. BUT THAT IS BY NO MEANS THE END OF IT.

THE BIOMEDICAL APPROACH -- SPECIFICALLY, THE USE OF DRUGS -- WILL BRING DOWN BLOOD PRESSURE BUT WILL NOT NECESSARILY KEEP IT DOWN WITHOUT PENALTIES FOR THE PATIENT. THESE WOULD INCLUDE THE SIDE EFFECTS OF THE MEDICATION -- DRY MOUTH, FOR EXAMPLE, OR EVEN IMPOTENCE -- AND THE COST OF THE DRUGS. THEY AREN'T CHEAP. THEREFORE, THE PHYSICIAN WHO RELIES ALMOST ENTIRELY ON DRUG THERAPY WILL SUFFER A PENALTY, ALSO: FAILURE AND FRUSTRATION OVER THE LONG TERM.

FOR MOST HYPERTENSIVES, THE THERAPY NEEDS TO BE BIOBEHAVIORAL:
EARLY ON, AN EMPHASIS ON DRUGS AND A START ON CHANGING LIFESTYLES.
THEN, AS THE BLOOD PRESSURE COMES UNDER CONTROL, THE EMPHASIS MAY
BEGIN TO SHIFT AWAY FROM DRUG THERAPY AND MOVE TOWARD LONG-TERM
BEHAVIORAL CHANGE. AT THAT POINT THE PATIENT HAS TO GET GREATER
CONTROL OVER HIS OR HER BEHAVIOR, CHANGE WHAT HAS TO BE CHANGED, AND
-- AGAIN, AS WITH SMOKING CESSATION -- MAINTAIN THE NEW PATTERNS OF
HEALTHFUL BEHAVIOR.

UNHAPPILY, THESE LONG-TERM BEHAVIORAL SOLUTIONS ARE NOT ALWAYS CLEARLY TRANSMITTED TO PATIENTS. MOST PHYSICIANS DON'T HAVE THE TEACHING SKILLS THAT MIGHT BE MOST EFFECTIVE WITH HYPERTENSIVE PATIENTS, NOR HAVE THEY BEEN TRAINED TO MONITOR BEHAVIORAL CHANGE OVER THE LONG RUN. YET, IT SEEMS TO ME THAT THAT'S PRECISELY THE KIND OF HEALTH CARE THAT WOULD BE FUNDAMENTAL TO SUCCESSFUL, LONG-TERM THERAPY FOR HYPERTENSION.

LIFE, AS A.P.A. MEMBERS KNOW QUITE WELL, IS NOT AN EITHER-OR PROPOSITION. NOR IS HEALTH. NOR IS THE PROMOTION AND MAINTENANCE OF HEALTH AN EITHER-OR PROPOSITION. MEDICAL PRACTICE, THEREFORE, NEEDS TO UNDERSTAND THE INTER-DEPENDENCE OF THE BIOMEDICAL AND THE BEHAVIORAL SCIENCES AND THE PRACTITIONER -- ESPECIALLY THE PRACTITIONER SPECIALIZING IN PRIMARY CARE -- MUST GET USED TO EMPLOYING BOTH, RATHER THAN RELYING EITHER ON ONE OR ON THE OTHER. GOOD PRACTICE IS RARELY THAT EXCLUSIVE.

THE BIOBEHAVIORAL EXPERIENCE WITH HYPERTENSION THAT I RECOUNTED EARLIER CAN BE REPEATED IN MANY OTHER AREAS AS WELL -- IN THE DETECTION AND CONTROL OF CARDIOVASCULAR DISEASE, IN THE TREATMENT OF CERTAIN DISEASES OF THE GASTROINTESTINAL TRACT, IN THE MANAGEMENT OF STRESS, AND IN THE RELATIVELY UNEXPLORED AREA OF PAIN MANAGEMENT.

BUT WHILE I'M OPTIMISTIC ABOUT THIS NEW DEVELOPMENT, I AM ALSO SENSITIVE TO SOME POTENTIAL ETHICAL PROBLEMS IT RAISES. FOR INSTANCE, WHEN TESTING THE SAFETY AND EFFICACY OF A HYPOTHESIZED BALANCE OF DRUG AND BEHAVIORAL THERAPY, WOULDN'T WE AT SOME POINT HAVE TO LOWER THE APPROVED DRUG DOSAGE LEVELS OR EVEN WITHDRAW THE DRUG ALTOGETHER? AND WHEN WE DO THAT, WOULD WE BE STEPPING INTO THAT TERRITORY WHERE WE MAY BE DENYING A PATIENT STANDARD TREATMENT? THIS QUESTION HAS COME UP IN JUST A FEW INSTANCES IN THE PAST, AS IN THE BIOBEHAVIORAL RESEARCH INTO DIABETES THERAPY. BUT IT IS STILL A VERY NEW AREA.

ONE MAJOR ISSUE, OF COURSE, IS THAT BEHAVIORAL THERAPY IS NOT COVERED BY ANYTHING LIKE THE "KEFAUVER-HARRIS DRUG AMENDMENTS."
THEREFORE, WE DO NOT MEASURE BEHAVIORAL RESEARCH RESULTS AGAINST A STANDARD ANALOGOUS TO THE "SAFE AND EFFECTIVE" CRITERIA IN DRUG RERSEARCH. FEW THERAPIES USED BY PSYCHOLOGISTS COULD CARRY A "FINAL PRINTED LABEL" LISTING ALL THE INDICATIONS, CONTRAINDICATIONS, PRECAUTIONS, WARNINGS, AND ADVERSE REACTIONS. I SERIOUSLY DOUBT THAT WE'LL EVER DEVELOP SUCH LABELING FOR PSYCHOTHERAPY. NEVERTHELESS, THE MORE DEEPLY WE PENETRATE THIS NEW BIOBEHAVIORAL AREA -- WHERE

MEASUREABLE PHENOMENA BECOME INTER-TWINED WITH INDETERMINATE, UN-PREDICTABLE PHENOMENA -- THE MORE WE'RE GOING TO HAVE TO LEARN ABOUT PROVIDING AT LEAST MINIMUM GUARANTEES FOR HUMAN RESEARCH SUBJECTS.

THIS IS AN AREA, BY THE WAY, IN WHICH THE AMERICAN PSYCHOLOGICAL ASSOCIATION -- AND DIVISION 38 IN PARTICULAR - COULD BE OF IMMENSE VALUE. YOU CAN PROVIDE A MUCH-NEEDED FORUM FOR THE DEVELOPMENT OF PROFESSIONAL STANDARDS FOR BIOBEHAVIORAL RESEARCH. IN A RECENT EDITORIAL WRITTEN FOR SCIENCE MAGAZINE, DR. DAVID HAMBURG, THE FORMER PRESIDENT OF THE INSTITUTE OF MEDICINE AND SOON TO BE PRESIDENT OF THE CARNEGIE FOUNDATION, WROTE...

"RECENT ADVANCES IN MOLECULAR AND CELLULAR BIOLOGY EXCEED WHAT ANYONE COULD HAVE IMAGINED AS RECENTLY AS A FEW DECADES AGO.

THEY LINK UP WITH OTHER FRONTS, SUCH AS NEUROBIOLOGY AND HUMAN BEHAVIOR. NOWHERE ARE THE NEEDS AND OPPORTUNITIES FOR PROGRESS IN THE BIOBEHAVIORAL SCIENCES CLEARER," SAYS DR. HAMBURG, "THAN IN PROBLEMS OF HEALTH AND HUMAN BEHAVIOR."

HE ALSO REFERS TO A RECENT REPORT HE CO-EDITED FOR THE INSTITUTE OF MEDICINE TITLED HEALTH AND BEHAVIOR: FRONTIERS OF RESEARCH IN THE BIOBEHAVIORAL SCIENCES. THAT REPORT IS VERY TIMELY, CONSIDERING THE WORK TO BE DONE IN PREVENTION AND HEALTH PROMOTION DURING THE NEXT SEVERAL DECADES. INCIDENTALLY, MUCH OF THE REPORT'S VALUE RESTS ON CONTRIBUTIONS BY MEMBERS OF DIVISION 38, ESPECIALLY DR. JUDITH RODIN, YOUR INCOMING DIVISION PRESIDENT, WHO WAS ALSO CO-EDITOR OF THAT REPORT. IT'S AN EXCELLENT DOCUMENT AND OUGHT TO BE IN YOUR LIBRARY, ALONG WITH HEALTHY PEOPLE AND OBJECTIVES FOR THE NATION.

SO FAR, I'VE HAD QUITE A LOT TO SAY ABOUT HAVING PEOPLE CHANGE THE WAY THEY LIVE. BUT EVEN YOUR SURGEON GENERAL KNOWS THAT LIFE DOESN'T WORK OUT QUITE THAT WAY. AND I THINK THAT'S A GOOD THING FOR ALL OF US. NO ONE HAS THE LICENSE TO IMPOSE PREVENTIVE HEALTH POLICIES AND REGIMENS ON THE GENERAL PUBLIC, MUCH LESS ON PHYSICIANS. THERE IS IN AMERICAN SOCIETY AN UNWRITTEN BUT NEVERTHELESS POWERFUL RULE THAT GOES SOMETHING LIKE THIS:

PEOPLE HAVE THE RIGHT TO DEFEND THEMSELVES FROM WHAT OTHER PEOPLE THINK IS GOOD FOR THEM.

WHAT, THEN, ARE SOCIETY'S OPTIONS FOR HANDLING PEOPLE WHO DON'T LIKE BREAKFAST, HATE EXERCISE, AND CHEW CANDY? OR THE PEOPLE WHO

DRIVE TOO FAST AND SMOKE TOO MUCH? IN SOME CASES, SOCIETY CAN FASHION LAWS TO PROTECT THE MAJORITY FROM ANY DANGER THAT MIGHT BE CAUSED BY THIS FECKLESS MINORITY: WE SET SPEED LIMITS AND MINIMUM DRINKING AGES ...WE REQUIRE VACCINATIONS AND DOUBLE THE EXCISE TAX ON CIGARETTES. THAT SORT OF THING.

BUT WHEN YOU LOOK OVER THE 15 HEALTH AREAS CATALOGUED IN <u>HEALTHY</u>

<u>PEOPLE</u>, YOU HAVE TO CONCLUDE THAT LAWS AND REGULATIONS PROBABLY PLAY A

MINOR ROLE IN OUR NATIONAL PUBLIC HEALTH STRATEGY. IN MOST INSTANCES,

COERCION IS SIMPLY NOT THE PROCEDURE OF CHOICE FOR SOCIAL CHANGE.

JAMES MADISON

THAT'S NOTHING NEW. ALMOST 200 YEARS AGO ALEXANDER HAMILTON WROTE, IN ONE OF THE LATER FEDERALIST PAPERS....

"...IT IS OF GREAT IMPORTANCE IN A REPUBLIC NOT ONLY TO GUARD AGAINST THE OPPRESSION OF ITS RULERS, BUT TO GUARD ONE PART OF SOCIETY AGAINST THE INJUSTICE OF THE OTHER."

SO WE MUST BE CAREFUL THAT, IN OUR ZEAL TO PRACTICE INNOVATIVE PRE-VENTIVE MEDICINE, WE NOT IMPOSE AN INJUSTICE UPON OUR NEIGHBOR. I BELIEVE THAT, IN THE FUTURE, WE WILL BE TURNING LESS OFTEN TO THE LAW FOR OUR PREVENTIVE MEDICINE, EVEN THOUGH, IN OUR FRUSTRATION, WE MIGHT WANT TO TAKE THAT PATH. HOWEVER, I WOULD COUNSEL THAT WE TURN MORE OFTEN TO THE BEHAVIORAL SCIENCES -- IN PARTICULAR, TO THE DISCIPLINES REPRESENTED IN HEALTH PSYCHOLOGY -- WHICH TEND TO BE INSTRUCTIVE AND PERSUASIVE RATHER THAN COERCIVE.

AND THAT BRINGS ME TO THE LAST SUBJECT I WANT TO RAISE WITH YOU THIS MORNING. THIS ALSO IS A SUBJECT INVOLVING ETHICAL STANDARDS OF BEHAVIOR AND OF THE CHOICES NOW PRESENTED TO THE PROFESSION OF PSYCHOLOGY...INDEED, TO ALL PROFESSIONS INVOLVED IN HEALTH RESEARCH. THE SUBJECT IS MISCONDUCT IN RESEARCH, SOMETHING THAT HAS CREPT INTO THE BEHAVIORAL AND BIOMEDICAL FIELDS IN THE PAST SEVERAL YEARS.

FIRST, IT'S IMPORTANT TO RECOGNIZE THAT AMERICAN RESEARCH -CARRIED OUT IN THE TRADITION OF FREE INQUIRY AND SHELTERED WITHIN OUR
GREAT ACADEMIC INSTITUTIONS -- STILL LEADS THE WORLD BY ANY MEASURE
YOU MAY CHOOSE. SINCE BECOMING SURGEON GENERAL, I HAVE BEEN
PRIVILEGED TO REPRESENT THE UNITED STATES IN MEETINGS OF THE WORLD
HEALTH ORGANIZATION AND TO SPEND MANY LONG HOURS WITH THE LEADING
HEALTH OFFICIALS OF OTHER COUNTRIES. AND ALWAYS THE MESSAGE IS THE

SAME: THE WORLD LOOKS TO US TO SET THE STANDARD BY WHICH MANKIND WILL MAKE PROGRESS IN HEALTH AND MEDICAL CARE. I WAS IMPRESSED WITH OUR RECORD BEFORE COMING TO GOVERNMENT. I'M EVEN MORE IMPRESSED NOW.

SO I AM DEEPLY TROUBLED -- AS WE ALL SHOULD BE -- WHEN THERE ARE INSTANCES OF MISCONDUCT IN RESEARCH. THIS IS AN ESPECIALLY IMPORTANT PROBLEM FOR US RIGHT NOW. WE ARE EMBARKING ON A LONG-TERM NATIONAL COMMITMENT TO PREVENTIVE CARE AND HEALTH PROMOTION. MOST OF OUR WORK SO FAR HAS BEEN CARRIED BY INSTINCT, ANECDOTAL REPORTS, VISCERAL RESPONSES, AND DOUBLE-BLIND CROSS-OVER GUESSING. BUT WE NEED A MUCH FIRMER DATA BASE UPON WHICH TO BUILD. THE BASE HAS TO BE SOLID.

IN MATTERS OF PERSONAL AND PROFESSIONAL INTEGRITY, JUST AS IN THE CHOICE OF MORE HEALTHFUL BEHAVIOR, I DON'T BELIEVE COERCION WORKS EITHER. I DON'T BELIEVE YOU CAN REGULATE HONESTY OR LEGISLATE HIGH ETHICAL STANDARDS OR MANDATE SPOTLESS PROFESSIONAL CONDUCT. RATHER, I BELIEVE THIS IS A PROBLEM THAT LIES AT THE DOORSTEP OF EVERY PROFESSIONAL ORGANIZATION AND INSTITUTION. IT IS ALSO THE PERSONAL RESPONSIBILITY OF EVERYONE ENGAGED IN THE BEHAVIORAL AND BIOMEDICAL SCIENCES. THE PROFESSION ITSELF MUST PUT INTO PLACE ITS OWN MECHANISMS FOR INSURING THE INTEGRITY OF RESEARCH.

IN THIS CONNECTION, I WANT TO QUOTE FROM A PARAGRAPH IN THE INTRODUCTION TO A NEW PAMPHLET PUBLISHED BY THE ASSOCIATION OF AMERICAN
MEDICAL COLLEGES. IT'S TITLED THE MAINTENANCE OF HIGH ETHICAL
STANDARDS IN THE CONDUCT OF RESEARCH. RATHER THAN PARAPHRASE, I AM
GOING TO QUOTE DIRECTLY FROM THE "INTRODUCTION":

"THE RESPONSIBILITY OF THE SCIENTIFIC COMMUNITY TO THE PUBLIC IS ACKNOWLEDGED," IT SAYS. "THE MAINTENANCE OF PUBLIC TRUST IN THIS PURSUIT IS VITAL TO THE CONTINUING VIGOR OF THE BIOMEDICAL RESEARCH ENTERPRISE." AND I WOULD MERELY TAKE OUT THE WORD "BIOMEDICAL" AND INSERT "TOTAL" INSTEAD. BUT TO CONTINUE..."LOSS OF THIS TRUST BECAUSE OF ISOLATED INSTANCES OF DISHONEST BEHAVIOR ON THE PART OF A FEW RESEARCHERS COULD CAUSE GREAT HARM BY CALLING INTO QUESTION IN THE MIND OF THE PUBLIC THE VALIDITY OF ALL NEW KNOWLEDGE AND THE INTEGRITY OF THE SCIENTIFIC COMMUNITY AT LARGE. IN SHORT, IT IS IN THE BEST INTEREST OF THE PUBLIC AND OF ACADEMIC MEDICINE TO PREVENT MISCONDUCT IN RESEARCH AND TO DEAL EFFECTIVELY AND RESPONSIBLY WITH INSTANCES WHERE MISCONDUCT IS SUSPECTED."

THIS IS A CALL TO ACTION FOR EVERYONE WHOSE LIFE IS BOUND TO THE PURSUIT OF NEW KNOWLEDGE. FOR PSYCHOLOGISTS WORKING ON THE FRONTIERS OF HUMAN BEHAVIOR, IT HAS A SPECIAL -- EVEN AN IRONIC -- SIGNIFICANCE. IN A SENSE, IT IS BEHAVIORAL RESEARCH TURNED IN UPON ITSELF.

AT A RECENT STAFF MEETING IN THE PUBLIC HEALTH SERVICE HEAD-QUARTERS, WE WERE DISCUSSING THE ISSUE OF THE REPORTING OF FRAUDULENT DATA AND OTHER ASPECTS OF MISCONDUCT IN RESEARCH. IN THE COURSE OF THE DISCUSSION IT WAS NOTED THAT, BETWEEN OCTOBER 1, 1980, AND THE END OF JUNE THIS YEAR, THERE WERE ONLY 45 CASES OF ALLEGED MISCONDUCT IN N.I.H.-SUPPORTED RESEARCH. THIS WAS OUT OF THE 12,000 TO 15,000 RESEARCH PROJECTS THAT HAD BEEN CARRIED ON DURING THE SAME PERIOD OF TIME.

THE FIRST RESPONSE BY SOME PERSONS AT THAT MEETING WAS, "WELL, 45 OUT OF 15,000 ISN'T SO BAD." THEN ONE SENIOR STAFF MEMBER SPOKE UP. HE SAID, "WE CAN'T PUT TOO MUCH WEIGHT ON THAT FIGURE. AFTER ALL, IN NEARLY EVERY OTHER SECTOR OF SOCIETY WHERE WE SEE EXAMPLES OF FRAUD AND ABUSE, WE SAY, 'AHA, I BET THAT'S ONLY THE TIP OF THE ICEBERG.'

WE ALL DO IT -- WITH ALLEGATIONS OF GOVERNMENT CORRUPTION, BUSINESS MISCONDUCT, WELFARE CHEATING, AND SO ON. WHY SHOULD THE PUBLIC -- OR WHY SHOULD WE, FOR THAT MATTER -- VIEW THAT NUMBER 45 WITH ANY LESS SKEPTICISM?"

I DON'T KNOW WHETHER HE WAS BEING FAIR OR NOT TO THE RESEARCH COMMUNITY. BUT I THINK HE WAS GIVING US THE RIGHT MESSAGE. HE WAS DEALING HEAD-ON WITH THE IMPORTANCE OF APPEARANCES AS WELL AS OF SUBSTANCE. OUR RESEARCH HAS TO BE EXCELLENT. THAT'S THE UNEQUIVOCAL STANDARD FOR SUBSTANCE. BUT IT ALSO HAS TO LOOK AS IF IT WILL PRODUCE EXCELLENCE. PUBLIC FAITH IN THE RESEARCH COMMUNITY RESTS UPON BOTH SUBSTANCE AND APPEARANCE -- AND I DON'T THINK THERE'S ANYTHING WRONG WITH THAT.

AFTER A MOMENT'S REFLECTION, I HAD TO AGREE THAT 45 OUT OF SO MANY THOUSANDS OF PROJECTS WAS NO LONGER IMPRESSIVE. I HAD TO CONCLUDE THAT, WITH THE SECOND CASE OF ALLEGED MISCONDUCT, WE HAD ACTUALLY HIT CRITICAL MASS. TWO SHOULD HAVE BEEN OUR ABSOLUTE LIMIT. THE OTHER 43 MERELY REINFORCE THE DANGERS POSED BY THE FIRST TWO.

I TEND TO BE AN OPTIMIST ABOUT THESE MATTERS, HOWEVER. I BELIEVE THAT, SOMEHOW, THE RESEARCH AND THE ACADEMIC COMMUNITIES WILL PUT TOGETHER A WAY OF ENFORCING THE HIGHEST STANDARDS OF RESEARCH, WITHOUT ENDANGERING FREEDOM OF INQUIRY. AND I SINCERELY HOPE EACH PERSON IN THE AUDIENCE THIS MORNING WILL DO WHATEVER NEEDS TO BE DONE TO HELP JUSTIFY MY OPTIMISM.

I PROMISED DR. MATTHEWS THAT I WOULD DEVOTE MY REMARKS TO "PERSPECTIVES OF FUTURE HEALTH CARE." MY PERSPECTIVES THIS MORNING MAY NOT BE VERY EXOTIC, BUT I SUBMIT THEM FOR YOUR THOUGHTFUL ATTENTION. I THINK THERE IS A GREAT NEED FOR PROFESSIONALS IN EVERY HEALTH DISCIPLINE TO GRAPPLE WITH...

- o THE GROWING IMPORTANCE OF PREVENTION AND HEALTH PROMOTION...
- o THE ROLE OF BEHAVIORAL CHANGE WITHIN THE PREVENTION STRATEGY...
- O THE ETHICAL QUESTIONS CONCERNING THIS STRATEGY AND THE PERSONS AFFECTED BY IT...

O AND FINALLY THE ISSUE OF MISCONDUCT IN SCIENCE, A VERY GRAVE MATTER THAT MUST NOT BE ALLOWED TO COMPROMISE THE STRENGTH OF BEHAVIORAL AND BIOMEDICAL RESEARCH IN THIS COUNTRY.

I AM CONFIDENT WE WILL ATTACK THESE ISSUES AND RESOLVE THEM IN THE YEARS AHEAD WITH OUR SOCIETY'S CHARACTERISTIC ENERGY. EARLIER I MENTIONED ALEXIS DETOQUEVILLE'S FASCINATION WITH AMERICAN BEHAVIOR, SO I WOULD LIKE TO CLOSE MY REMARKS THIS MORNING WITH AN OBSERVATION HE MADE IN HIS BOOK, DEMOCRACY IN AMERICA, NEARLY 150 YEARS AGO:

"AMERICA IS A LAND OF WONDERS," HE WROTE, "IN WHICH EVERYTHING IS
IN CONSTANT MOTION AND EVERY CHANGE SEEMS AN IMPROVEMENT." AND AS FAR
AS THE AVERAGE AMERICAN IS CONCERNED, SAID DETOQUEVILLE, "IN HIS EYES,
WHAT IS NOT YET DONE IS ONLY WHAT HE HAS NOT YET ATTEMPTED TO DO."

I THINK THAT WE <u>STILL ARE</u> THE NATION OF DETOQUEVILLE'S VISION AND THAT WE <u>WILL DO</u> THOSE THINGS "NOT YET DONE" IN PUBLIC HEALTH.

THANK YOU AGAIN FOR YOUR GRACIOUS INVITATION TO HAVE ME JOIN YOU. PLEASE ACCEPT MY BEST WISHES FOR A SUCCESSFUL ANNUAL MEETING.

THANK YOU.

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